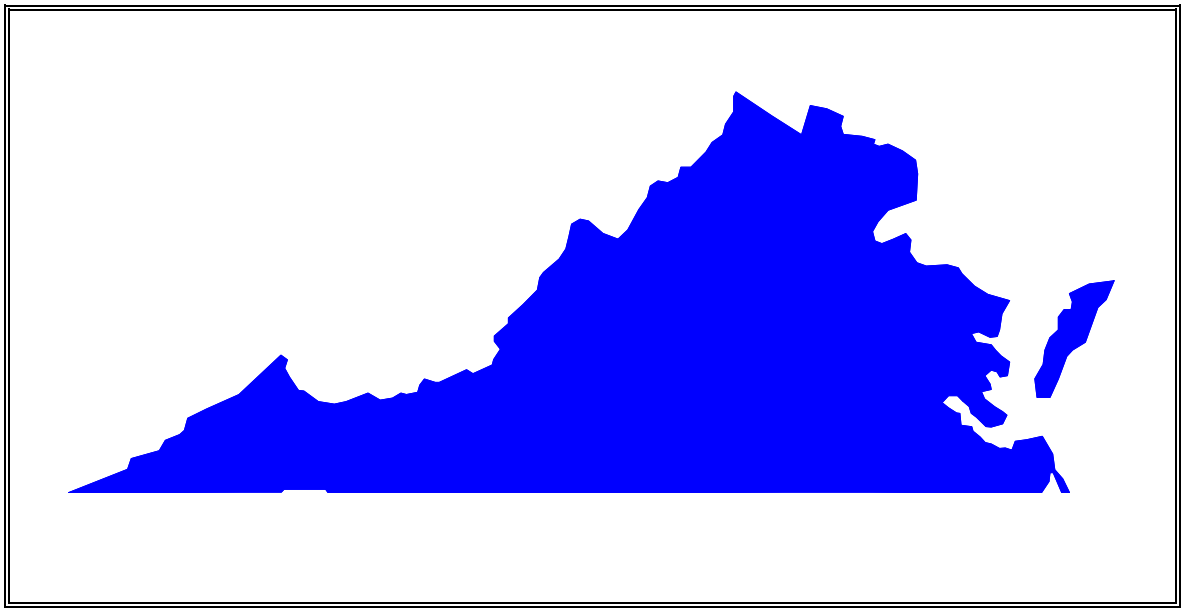
Virginia Department of Medical Assistance Services

Companion Guide

For 837 Institutional Health Care Claim & Encounter Transactions

Version 1.11 Updated 04/01/2008



ASC X12N 837
VERSION 004010 X096A1

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VERSION CHANGE SUMMARY

VERSION NO.	DESCRIPTION	DATE
Version 1.0 – 1.1	Original Implementation	12/05/2002
Version 1.2 -	Modified Comments (page ref. 192) Loop 2300 – REF02 – Claim Org. Ref. Number	04/11/2003
Version 1.3 -	Modified Comments (page ref. 199) Loop 2300 – REF02 – Prior Authorization No.	08/21/2003
Version 1.4 -	Added Page reference 182 Loop 2300 – AMT information Updated Page reference 371 Loop 2320 – AMT01 – Amount Qualifier, Comments	03/01/2004
Version 1.5 -	Added comments for providers submitting Medicare coinsurance & deductible claims Added note 6 under Special Notes Changed Page reference 84 Loop 2010AA – REF02 Changed Page reference 110 Loop 2010BA – NM109 Added Page reference 363 Loop 2320 – SBR09 Added Page reference 372 Loop 2320 – AMT01 & AMT02 Added Page reference 373 Loop 2320 – AMT01 & AMT02 Added Page reference 376 Loop 2320 – AMT01 & AMT02 Added Page reference 403 Loop 2330A – NM109 Added Page reference 411 Loop 2330B – NM109 Changed Page reference 496 Loop 2430 – CAS02	08/05/2004
Version 1.6 -	· Modified comments (page reference 68) Loop 1000B - NM103 Name Last or Organization Name · Added comments (page reference 446) Loop 2400 - SV201 Service Line Revenue Code	08/19/05

Version 1.7 - · Added comments (page reference 159) 04/07/06
Loop 2300 – CLM05-3 Claim Frequency Code

Version 1.8 - **NPI modifications** 12/01/06
Modified comments (page reference **71**)
Loop 2000A – PRV03 Provider Taxonomy Code
Modified comments (page reference **77**)
Loop 2010AA – NM108 Billing Provider Identification Code
Modified comments (page reference **81**)
Loop 2010AA – N403 Billing Provider's Zip Code
Modified comments (page reference **83**)
Loop 2010AA – REF01 Identification Code
Modified comments (page reference **84**)
Loop 2010AA – REF02 Identification Code
Modified comments (page reference **323**)
Loop 2310A – NM108 Attending Physician Identification Code
Modified comments (page reference **326**)
Loop 2310A – REF01 Identification Code
Modified comments (page reference **327**)
Loop 2310A – REF02 Identification Code
Modified comments (page reference **330**)
Loop 2310B – NM108 Operating Physician Identification Code
Modified comments (page reference **333**)
Loop 2310B – REF01 Identification Code
Modified comments (page reference **334**)
Loop 2310B – REF02 Identification Code
Modified comments (page reference **337**)
Loop 2310C – NM108 Other Provider Identification Code
Modified comments (page reference **340**)
Loop 2310C – REF01 Identification Code
Modified comments (page reference **341**)
Loop 2310C – REF02 Identification Code
Modified comments (page reference **411**)
Loop 2330B – NM109 Other Payer Primary Identification Code

Version 1.9 – 06/06/2007
Modified Special Notes 7 , 8 & 9
Contingency Dual Use Period
Modified comments (page references **84, 327, 334 & 341**)
Contingency Dual Use Period

Version 1.10 10/01/2007
Modified comments (page reference **81**)
Loop 2010AA – N403 Billing Provider's Zip Code

Version 1.11 04/01/2008

Modified Special Notes – deleted notes 5 & 6; modified notes 7, 8 & 9 – notes renumbered

Removed blue highlighting from previous changes

Modified comments for NPI and API usage

- Loop 2010AA NM108 **(page reference 77)**
- Loop 2010AA REF01 **(page reference 83)**
- Loop 2010AA REF02 **(page reference 84)**
- Loop 2310A NM108 **(page reference 323)**
- Loop 2310A REF01 **(page reference 326)**
- Loop 2310A REF02 **(page reference 327)**
- Loop 2310B NM108 **(page reference 330)**
- Loop 2310B REF01 **(page reference 333)**
- Loop 2310B REF02 **(page reference 334)**
- Loop 2310C NM108 **(page reference 337)**
- Loop 2310C REF01 **(page reference 340)**
- Loop 2310C REF02 **(page reference 341)**

Modified comments for NDC

- Loop 2410 LIN02 **(page reference 37 Addenda)**
- Loop 2410 LIN03 **(page reference 37 Addenda)**
- Loop 2410 CTP03 **(page reference 39 Addenda)**
- Loop 2410 CTP04 **(page reference 39 Addenda)**
- Loop 2410 CTP05 **(page reference 39 Addenda)**

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

PURPOSE

- For providers with a FFS agreement to submit claims for payment.
- For HMOs with a capitated agreement to submit encounters for reporting purposes.

SPECIAL NOTES

1. 837 Claims or Encounters may be sent at anytime 24 hours a day, 7 days a week, however...
   A) Fee-for-service Claims submitted by mid-afternoon will be processed in the current daily cycle. Claims submitted after 1 PM EST on Fridays will not be included in the current week's remittance cycle.
   B) Encounters should be submitted prior to noon on their scheduled submission date.

2. The 997 Response will normally be available for pickup 1 hour after file submission unless there are unforeseen technical difficulties.
3. Claim and Encounters should be submitted in separate ISA-IEA envelopes.
4. All references to Medicaid are used for simplicity, but other programs supported by DMAS are also included, such as FAMIS, SLH, and TDO.

5. As of May 23, 2008, only the NPI will be accepted and used to adjudicate healthcare claims. All claims and encounters received on or after that date will be processed using the NPI or Atypical Provider Identifier (API). **The compliance is based on the date of receipt and not the date of service.**

6. Non-healthcare providers that are not eligible to obtain an NPI will be assigned a new 10-digit Virginia Medicaid Atypical Provider ID (API). Beginning May 23, 2008, the API must be used in place of the Legacy ID.

7. Medicare coinsurance and deductible claims must be submitted using the NPI.
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Data Element Descriptions

Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	Use "00" – No Authorization Information Present
B.3	N/A	ISA	ISA03 – Security Information Qualifier	Use "00" – No Security Information Present
B.3	N/A	ISA	ISA05 – Interchange ID Qualifier	Use "ZZ" – Mutually defined
B.3	N/A	ISA	ISA06 – Interchange Sender ID	Use 4-character service center ID assigned by Virginia Medicaid
B.3	N/A	ISA	ISA08 – Interchange Receiver ID	Use "VMAP FHSC FA"
B.3	N/A	ISA	ISA14 – Acknowledgment Requested	Use "0" – No Acknowledgement Requested
B.3	N/A	GS	GS02 – Application Sender's Code	4 digit Service Center ID assigned by Virginia Medicaid
B.3	N/A	GS	GS03 – Application Receiver's Code	Use "VMAP FHSC FA"
B.3	N/A	GS	GS08 – Version/Release Industry ID Code	Use "004010X096A1".
60	N/A	REF	REF02- Transmission Type Code	Use "004010X096A1".
68	1000A	NM1	NM109-Submitter Primary Identifier	Use 4-character service center ID assigned by Virginia Medicaid.
68	1000B	NM1	NM103-Name Last or Organization Name	Use "Dept of Med Assist Svcs"
71	2000A – Billing/Pay-To Provider	PRV	PRV03 – Provider Taxonomy Code	DMAS requires taxonomy codes on claims when the provider has not enumerated with separate NPIs based on the type of service being provided. Taxonomy codes do not need to be sent with an API.
77	2010AA – Billing Provider Name	NM1	NM108 – Identification Code Qualifier	24 – Employer's Identification Number 34 – Social Security Number XX – NPI Note: If XX – NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop

Page	Loop	Segment	Data Element	Comments
81	2010AA – Billing Provider Name	N4	N403 – Billing Provider's Zip Code	The billing provider zip code (along with the address information in the 2010AA N3 segment) is required and may be used for pricing. Providers are required to submit the 9-digit zip code when available.
83	2010AA-Billing Provider Secondary ID	REF	REF01-Reference Identification Qualifier	Note: Medicaid will pay the billing provider and not the Pay-to-provider (loop 2010AB). 1D – Medicaid Provider Number EI – Employer's Identification Number SY – Social Security Number Note: EI or SY must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop. Note: When the API is sent, use the 1D qualifier.
84	2010AA	REF	REF02-Billing Provider Secondary Identifier	Note: Beginning 5/23/08, only the 10-digit API should be submitted using the 1D qualifier. When sending the EI qualifier, use the Employer Identification Number. When sending the SY qualifier, use the SSN.
110	2010BA-Subscriber Name	NM1	NM108-Identification Code Qualifier	Use "MI".
110	2010BA	NM1	NM109-Subscriber Primary Identifier	Use the patient's 12-digit enrollee ID number. **Note: For providers submitting Medicare coinsurance & deductible claims, use the Medicaid ID.
158	2300-Claim Information	CLM	CLM01-Claim Submitter's ID	For Encounters, use the HMO's claim number.

Page	Loop	Segment	Data Element	Comments
159	2300-Claim Information	CLM	CLM05-3 Claim Frequency Code	Use "1" for original claim. Use "7" for replacement. Use "8" for void. For claims with an admission date of 3/1/2006 or later, as well as for all claims reimbursed using DRG (inpatient and rehab hospitals), use the standard frequency codes to appropriately indicate interim bills. For claims with an admission date prior to 3/1/2006 that are not reimbursed using DRG (i.e., other than inpatient and rehab hospitals), always use '1' for the frequency of an original claim.
173	2300 - Claim Information	PWK	PWK06– Attachment Control Number	Use if PWK02 = "BM", "EL", "EM", or "FX" The Attachment Control Number is a composite of three specific fields and can be up to 33 positions with no embedded spaces or special characters (i.e., slashes, dashes, etc.): The **first** field is the Patient Account Number (Provider assigned) and can be a maximum of 20 positions. The **second** field is the From Date Of Service (DOS) associated with the first line on the claim - MMDDCCYY. The **third** field is a sequential number (5 positions, numeric) established/incremented by the Provider for every electronic claim submitted. The sequence # is right justified, zero filled. The Attachment Control Number should be the same for every attachment associated with a specific claim.
176	2300 - Claim Information	CN1	CN101-Contract Type Code	Required for Encounters.
182	2300	AMT	AMT01 – Amount Qualifier	Use 'F5' when submitting nursing home patient payment amounts.

Page	Loop	Segment	Data Element	Comments
191	2300	REF	REF01-Reference ID Qualifier	Use "F8" when submitting a claim replacement or void/cancel (as indicated by CLM05-3).
192	2300	REF	REF02-Claim Original Reference Number	For FFS claims, use the 16 character Reference Number assigned by Virginia Medicaid. Note: For encounters, this should be the HMO's original claim number (up to 20 characters).
198	2300	REF	REF01-Reference ID Qualifier	Use "G1" when submitting a prior authorization number.
199	2300	REF	REF02-Prior Authorization Number	Use 11 character number assigned by Virginia Medicaid.
206	2300	NTE	NTE02-Claim Note Text	Provide free-text remarks, if needed. Virginia Medicaid will use first occurrence of this segment.
209	2300	NTE	NTE02-Billing Note Text	Provide free-text remarks, if needed.
228	2300	HI	HI02-1 Admitting Diagnosis	Use "BJ" for Admitting Diagnosis Note: Virginia Medicaid only recognizes and accepts ICD-9-CM diagnosis and procedures.
230	2300	HI	HI01-2 Diagnosis Related Group	Required for Claims or Encounters if paid by DRG.
242	2300	HI	HI01-1 Principal Procedure Information	Use "BR" (ICD9 Principal Procedure)
243	2300	HI	HI01-2 Principal Procedure Code	See the ICD-9 CM Code book for acceptable procedure codes.
244-255	2300	HI	HI01-1, HI02-1, …, HI12-1 Code List Qualfier Code	Use "BQ" (ICD9 Procedure)
244-255	2300	HI	HI01-1, HI02-1, …, HI12-1 Procedure Code	See the ICD-9 CM Code book for acceptable procedure codes.
323	2310A-Attending Physician Name	NM1	NM108 – Identification Code Qualifier	24 – Employer's Identification Number 34 – Social Security Number XX – NPI Note: If XX – NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop.

Page	Loop	Segment	Data Element	Comments
326	2310A-Attending Physician Name	REF	REF01-Reference Identification Qualifier	1D – Medicaid Provider Number EI – Employer's Identification Number SY – Social Security Number Note: EI or SY must be used when the 10-digit NPI is sent in the Referring Provider Name segment of this loop. Note: When the API is sent, use the 1D qualifier.
327	2310A	REF	REF02-Attending Physician Secondary Identifier	Note: Beginning 5/23/08, when sending the 1D qualifier use the 10-digit API. When sending the EI qualifier, use the Employer Identification Number. When sending the SY qualifier, use the SSN.
330	2310B-Operating Physician Name	NM1	NM108 – Identification Code Qualifier	24 – Employer's Identification Number 34 – Social Security Number XX – NPI Note: If XX – NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop.
333	2310B - Operating Physician Name	REF	REF01-Reference Identification Qualifier	1D – Medicaid Provider Number EI – Employer's Identification Number SY – Social Security Number Note: EI or SY must be used when the 10-digit NPI is sent in the Referring Provider Name segment of this loop. Note: When the API is sent, use the 1D qualifier.

Page	Loop	Segment	Data Element	Comments
334	2310B	REF	REF02- Operating Physician Secondary Identifier	Note: Beginning 5/23/2008, only the 10-digit API should be submitted using the 1D qualifier. When sending the EI qualifier, use the Employer Identification Number. When sending the SY qualifier, use the SSN.
337	2310C– Other Provider Name	NM1	NM108 – Identification Code Qualifier	24 – Employer's Identification Number 34 – Social Security Number XX – NPI Note: If XX – NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop.
340	2310C– Other Provider Name	REF	REF01-Reference Identification Qualifier	1D – Medicaid Provider Number EI – Employer's Identification Number SY – Social Security Number Note: EI or SY must be used when the 10-digit NPI is sent in the Referring Provider Name segment of this loop. Note: When the API is sent, use the 1D qualifier.
341	2310C	REF	REF02- Other Physician Secondary Identifier	Note: Beginning 5/23/08, when sending the 1D qualifier use the 10-digit API. When sending the EI qualifier, use the Employer Identification Number. When sending the SY qualifier, use the SSN.
359	2320 – Other Subscriber Information	SBR		If the patient has Medicare or other coverage, repeat this loop for each other payer. Do not put information about Virginia Medicaid coverage in this loop.

Page	Loop	Segment	Data Element	Comments
363	2320 – Other Subscriber Information	SBR		**Note: For providers submitting Medicare coinsurance & deductible claims, use "MA" or "MB" to indicate a Medicare payer.
365	2320 – Other Subscriber Information	CAS	CAS02 – Claim Adjustment Reason Code	For HMO submitted denied Encounters, use CAS02 Claim Adjustment Reason Code (code source 139) to indicate the denial reason. **Note: For providers submitting Medicare coinsurance & deductible claims –Use "1" for Deductible amounts Use "2" for Coinsurance amounts Use "66" for Blood Deductible amounts Adjustment amounts may be reported at the claim line or service line but not both.
371	2320	AMT	AMT01 – Amount Qualifier	Use "C4" – prior payment actual, to report third party payments.
371	2320	AMT	AMT02- Other Payer Paid Amount	All prior payments should be reported to Virginia Medicaid using this segment for the appropriate payer. **Note: For providers submitting Medicare coinsurance & deductible claims - Use "N1" to report the Total Medicare Paid Amount.
372	2320	AMT	AMT01 – Amount Qualifier	**Note: For providers submitting Medicare coinsurance & deductible claims –Use "B6" – to report the Total Allowed Amount
372	2320	AMT	AMT02- COB Total Allowed Amount	**Note: For providers submitting Medicare coinsurance & deductible claims report Total Allowed Amount
373	2320	AMT	AMT01 – Amount Qualifier	**Note: For providers submitting Medicare coinsurance & deductible claims –Use "T3" –to report the Total Billed charges
373	2320	AMT	AMT02- COB Total Submitted Charges	**Note: For providers submitting Medicare coinsurance & deductible claims report Total Billed Charges
376	2320	AMT	AMT01 – Amount Qualifier	**Note: For providers submitting Medicare coinsurance & deductible claims –Use "N1" – to report the Total Medicare Paid Amount

Page	Loop	Segment	Data Element	Comments
376	2320 – Other Subscriber Information	AMT	AMT02- COB Total Medicare Paid Amount	**Note: For providers submitting Medicare coinsurance & deductible claims report Total Medicare Paid Amount
403	2330A – Other Subscriber Name	NM1	NM109 – Other Insured Identifier	**Note: For providers submitting Medicare coinsurance & deductible claims – Use the Medicare ID for the enrollee
411	2330B – Other Payer Name	NM1	NM109 – Other Payer Primary ID#	**Note: For providers submitting Medicare coinsurance & deductible claims – 2330B, NM109 should match the value you are submitting in 2430, SVD01
446	2400 – Service Line	SV2	SV201 – Service Line Revenue Code	Virginia Medicaid requires a 4 digit revenue code. If a 3 digit revenue code is submitted, it will be right justified and zero filled.
446	2400	SV2		Virginia Medicaid recommends submitting 350 or fewer service lines for each institutional claim. Claims submitted with more than 350 service lines may be subject to processing delays.
37 Addenda	2410 – Drug Identification	LIN	LIN02 – Product or Service ID Qualifier	Use “N4” for NDC.
37 Addenda	2410 – Drug Identification	LIN	LIN03 – National Drug Code	An NDC is required when a drug is dispensed and the bill type (2300, CLM05-1) is ‘13’. Virginia Medicaid will capture only the first occurrence of the LIN segment for each revenue line. If billing for a compound medication with more than one NDC, then each applicable NDC must be sent as a separate revenue line.
39 Addenda	2410 – Drug Pricing	CTP	CTP03 – Unit Price	This value is required for this segment to be complete, but Virginia Medicaid will not use this value in pricing. A zero dollar amount is acceptable.

Page	Loop	Segment	Data Element	Comments
39 Addenda	2410 – Drug Pricing	CTP	CTP04 – Quantity	Input the actual NDC quantity dispensed
39 Addenda	2410 – Drug Pricing	CTP	CTP05 – Composite Unit of Measure	Input the unit/basis of measure
496	2430 – Service Line Adjudication Information	CAS	CAS02 – Claim Adjustment Reason Code	For HMO submitted denied Encounters, use CAS02 Claim Adjustment Reason Code (code source 139) to indicate the denial reason. **Note: For providers submitting Medicare coinsurance & deductible claims – Use “1” for Deductible amounts Use “2” for Coinsurance amounts Use “66” for Blood Deductible amounts Adjustment amounts may be reported at the claim line or service line but not both.